

Mr G W Theobald (*University College Hospital, London*) said that the width of approach of the opening speakers had made it difficult to pinpoint any subject for discussion. Miss Barnes had quoted figures concerning induction of labour from the Perinatal Mortality Survey. A wide variety of methods including castor oil and hot baths were still used, but the disquieting feature was the apparent complacency often shown after doing amniotomy, women being left for several days without further treatment.

The Edinburgh School had started an intense phase of inducing labour with the idea of lowering the perinatal mortality and had expected, for no stated reason, a greatly increased operative rate, which they got. Dr Sturrock had concluded that the perinatal mortality rate had not thereby been reduced. He had limited himself to the perinatal mortality for the hospital and had not disclosed the figures for labours induced or those for the area served by the hospital. Since an increased number of non-booked patients had been admitted during the years under review his figures may have been better than he thought.

Professor Lennon had quoted excellent figures and a low operative rate, in marked contrast to those from Edinburgh. As 80% of all pregnant women near term went into labour within twenty-four hours of amniotomy, he was surely wise in waiting until the day after amniotomy before starting the oxytocin drip. It was a pity that he had spoken of the number of drops instead of the number of milliunits of oxytocin per minute. His figures were so similar to those from Bradford (Theobald 1963) that he had probably given similar amounts of oxytocin.

Labour could only occur when the myometrium became sensitive to the minute amounts of oxytocin released from the neurohypophysis (assuming it to be the hormone devised by nature for instituting labour) and this presupposed a change in myometrial sensitivity to it, otherwise induction would be unnecessary. If the amount of oxytocin in the drip were continually increased the danger point would arise when a sudden increase occurred in myometrial sensitivity to it. There was at present no evidence that large amounts of oxytocin were more effective than small in causing this essential change.

Induction of labour could be a very rewarding procedure, but no unnecessary risks could be tolerated. The time had come for controlled experiments to see whether the absolutely safe physiological drip was as effective as the potentially dangerous pharmacological one. There

should be no need in this Section to stigmatize as retrograde any attempt to give so powerful a hormone by any other route than a vein.

REFERENCE

Theobald G W
(1963) In: *British Obstetric Practice*. Ed. A Claye. London; p 1055

Mr Alistair Gunn (*London*) commented on three matters: (1) Post-maturity had been referred to by all the speakers as though it were a primary obstetric condition. Nothing was likely to give worse results. Postmaturity was a symptom pointing to conditions which, if they were not recognized early and treated, were bound to have a high foetal loss rate: the most important of these was uterine inertia. A critical examination should be made before the membranes were ruptured to assess the size and shape of the pelvis and to recognize signs of the inertia syndrome, so that in appropriate cases Caesarean section could be done in good time.

(2) He condemned the routine use of antibiotics like penicillin and streptomycin in all women whose membranes had been ruptured for over twenty-four hours. Nothing could create greater danger than to destroy all the sensitive bacteria and leave resistant organisms quite unopposed. It must be remembered that bacteria had a struggle to exist amongst themselves and surviving resistant forms might include pathogens which would then have the field to themselves. Intra-amniotic infection was likely to occur if a faulty technique was employed to rupture the forewaters. The vagina had its own bacterial defence which would be impaired by introducing antiseptics and by causing bleeding from the cervix; he therefore inserted dry sterile gloved fingers into the vagina, used no antiseptic and took great care to avoid making the cervix bleed. 'Sweeping' the membranes was never done.

(3) Why did rupture of the forewaters make labour start and what method would make it start most quickly? He recalled that Eton (1959), with the methods he described, had reported the quickest induction-delivery intervals and the lowest incidence of maternal pyrexia yet published. The pregnant uterus had a rhythm of contraction and relaxation, the muscle fibres returning to their previous length when each contraction passed off; if a large amount of liquor was suddenly released the space in the uterus had to be taken up and so one or two contractions were followed by one or two large retractions; if, however, the liquor was released through a very small hole in the membranes without displacing